

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

Seymour

02983

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>TALBOT</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Easton</u> LENGTH OF STAY (In this place) <u>most of life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>503 Goldsboro St.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>503 Goldsboro</u>		STREET ADDRESS (If rural, give location) <u>Easton, Md.</u>	
3. NAME OF DECEASED (Type or Print) <u>Nettie May Berridge</u>		4. DATE OF DEATH (Month) <u>MAR.</u> (Day) <u>31</u> (Year) <u>1951</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>single</u>	8. DATE OF BIRTH <u>Jan. 19 1878</u>
9. AGE last birthday <u>73</u> yrs.		10. AGE last birthday If under 1 year: Months <u>2</u> Days <u>12</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>No occupation</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>Talbot Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Solomon N. Berridge</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth M. Merrick</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NONE</u>		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT <u>Mar. Elmer Marvel Easton Md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cerebral hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

4 days

Antecedent cause(s)

(b)

Arterio-Sclerosis with Hypertension7 yrs.

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐
(STATE)21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec., 1944 to March, 1951, that I last saw the deceasedalive on Mar. 30th, 1951, and that death occurred at 4:15 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL. (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REG'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4/2/51N.H. NeerriesMAURICE E. NEWNAM & SON
EASTON, Md.VVVVVV

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02984

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH: COUNTY <u>Talbot Co.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>St. Michaels</u> COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>St. Michaels</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Ernest</u> (First) <u>H</u> (Middle) <u>Burns</u> (Last)		4. DATE OF DEATH <u>March 5</u> (Month) <u>5</u> (Day) <u>1951</u> (Year)	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 6, 1883</u>
9. AGE last birthday <u>67</u> yrs.		10. AGE last birthday If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Poultry owner of poultry farm</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mr James Burns</u>		14. MOTHER'S MAIDEN NAME <u>Olivia Harrison</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Mrs Grace Burns</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Coronary Thrombosis

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.Diabetes Mellitus

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Mar. 3, 1951, to Mar. 5, 1951, that I last saw the deceased alive on March 5, 1951, and that death occurred at 11:05 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>3/7/51</u>	<u>St. Michaels</u>	<u>St. Michaels</u>	<u>MD</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>3/6/51</u>	<u>H. A. Neerius</u>	<u>Norman H. Marshall</u>	<u>St. Michaels, MD</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 02985290

1. PLACE OF DEATH: COUNTY <u>Talbot</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Beltone</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Talbot</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Beltone</u> TOWN STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Laura</u> (Middle) <u>Virginia</u> (Last) <u>Cullbourn</u>		4. DATE OF DEATH (Month) <u>Mar</u> (Day) <u>21</u> (Year) <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Black</u>	7. SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 4 - 1881</u>
9. AGE last birthday <u>70</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Beltone, Md.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Master Barber</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Turner</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Haskins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-14-4009</u>	
17. INFORMANT AND ADDRESS <u>Amberly Turner, Estate, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>Hypertensive Heart Disease</u>		
(a) Immediate cause <u>On a arteriosclerotic Cardiovascular basis</u>		<u>5 or more</u>
(b) Antecedent cause(s) <u>Active Rheumatoid Arthritis, Hypertension</u>		<u>years</u>
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>		
19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION <u>XXXXXXXXXXXXXXXXXXXX</u>	20. AUTOPSY? <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>No</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>XXXXXXXXXXXX</u>	(CITY OR TOWN) <u>XXXXXXXXXXXX</u> (COUNTY) <u>XXXXXXXXXXXX</u> (STATE) <u>XXXXXX</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>XXXXXXXXXXXX</u> m.	INJURY OCCURRED <u>While at Work</u>	HOW DID INJURY OCCUR? <u>XXXXXXXXXXXX</u>

22. I hereby certify that I attended the deceased from 3.21.51, 19....., to 3.21.51, 19....., that I last saw the deceased alive on 3.20.50, 19....., and that death occurred at 7.30.....m., from the causes and on the date stated above.

SIGNATURE: Philip D. Lewis (Degree or title) M.D. ADDRESS St. Michaels, Maryland DATE SIGNED 3.22.51

23. BURIAL OR CREMATION REMOVAL (Specify) <u>Interred</u>	DATE THEREOF <u>Mar 24-51</u>	NAME OF CEMETERY OR CREMATORY <u>St. Luke Cemetery</u>	LOCATION (City, town, or county) <u>Beltone, Md.</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>3/22/51</u>	REGISTRAR'S SIGNATURE <u>N.H. Neirna</u>	24. FUNERAL DIRECTOR <u>John D. Williams</u>	ADDRESS <u>Esten Rd.</u>	

MARGIN RESERVED FOR BINDING

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02986
Reg. Dist. No. 290

1. PLACE OF DEATH- COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Sadie</u>	(Middle) <u>Gertrude</u>	(Last) <u>Dobson</u>
4. DATE OF DEATH	(Month) <u>Mar</u>	(Day) <u>13</u>	(Year) <u>1957</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Black</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 2, 1895</u>
9. AGE last birthday <u>65</u> yrs.		10. AGE last birthday If under 1 year: Months <u>7</u> Days <u>11</u> If under 24 hrs: Hours <u>11</u> Mins. <u>11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Chapel, Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Henry Stevens</u>		14. MOTHER'S MAIDEN NAME <u>Frances Ann Rebecca Thomas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Margaret Thomas, Easton, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Inflection

Antecedent cause(s)

(b) same

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c) none

INTERVAL BETWEEN ONSET AND DEATH

3-4 day
PII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE	INJURY			
HOMICIDE				
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 3/13, 1957, to 3/13, 1957, that I last saw the deceased alive on 3/13, 1957, and that death occurred at 7 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Mar 19-1957</u>	<u>Old Chapel Cemetery, Goddard</u>	<u>Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>3/19/57</u>	<u>N.D. Neer</u>	<u>John D. Williams</u>	<u>Easton, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02987
Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <u>Talbot Co.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Easton, Md.</u> LENGTH OF STAY (in this place) <u>7 hrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pridgety</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u></u>	
3. NAME OF DECEASED (Type or Print) <u>Victor</u> (First) <u>Flamer</u> (Middle) <u>Flamer</u> (Last)		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>17</u> (Year) <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Black</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Jan 1, 1895</u>
9. AGE last birthday <u>56</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>Bascolm Flamer</u>	
14. MOTHER'S MAIDEN NAME <u>Josephine Douglas</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>	
16. SOCIAL SECURITY No. <u>Unknown</u>		17. INFORMANT <u>Little Flamer</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>myocardial infarction</u>	<u>1 day</u>	
Antecedent cause(s) (b) <u>arteriosclerotic Heart Disease</u>	<u>?</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Diabetes mellitus</u>		<u>?</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) <u></u> (COUNTY) <u></u> (STATE) <u></u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u></u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u></u>

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on March 17, 1957, and that death occurred at 2:15 A.M. from the causes and on the date stated above.

SIGNATURE J. B. Coe M.D. ADDRESS Easton Md DATE SIGNED 3/20/57

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Mar. 20, 1957</u>	NAME OF CEMETERY OR CREMATORY <u>Spring Grove</u>	LOCATION (City, town, or county) <u>Penton, Maryland</u> (State) <u></u>
DATE REC'D BY LOCAL REG. <u>3/17/57</u>	REGISTRAR'S SIGNATURE <u>N.H. Neeress</u>	24. FUNERAL DIRECTOR <u>J. Virgo Mooreson</u>	ADDRESS <u>Penton, Md</u>

MARGIN RESERVED FOR BINDING

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FOOTNOTES TO THE REPORT OF THE COMMISSIONER

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THE REPORT OF THE COMMISSIONER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02988

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH- COUNTY <u>Talbot</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>		MARYLAND LENGTH OF STAY (in this place) <u>5 hrs</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Greensboro</u> COUNTY <u>Caroline</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>MD</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>James</u> (Middle) <u>H.</u> (Last) <u>Gibbs</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>12</u> (Year) <u>1951</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Wgn</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>11-19-80</u>	9. AGE last birthday <u>70</u> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Barber Shop</u>	11. BIRTHPLACE (State or foreign country) <u>Greensboro Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Murray</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT AND ADDRESS <u>Ellen Williams</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) arteriosclerotic heart disease 2 yrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/12/51, 1951 to 3/12/51, 1951, that I last saw the deceased alive on 3/12/51, and that death occurred at 6:40 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

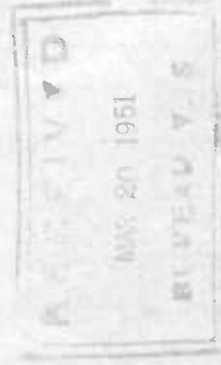
ADDRESS

Burial 3/15/51 Kokers near Greensboro Md
3/13/51 N.H. Neer P.B. Rawlings Greensboro Md.
970849

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02989
Reg. Dist. No. 290

1. PLACE OF DEATH- COUNTY <u>Sacchar</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Sacchar</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Easton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Julia</u>	(Middle) <u>F.</u>	(Last) <u>Goodenough</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>July 25, 1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>56</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Mln.
11. BIRTHPLACE (State or foreign country) <u>Sacchar County Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Maximilian Goodenough</u>		14. MOTHER'S MAIDEN NAME <u>Julia Blum</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>Philip Goodenough</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Uremia</u>		<u>1 month</u>
Antecedent cause(s) (b) <u>Nephrosclerosis</u>		<u>2 yrs?</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/1/57, 1957, to 3/17/57, 1957, that I last saw the deceased alive on 3/17/57, 1957, and that death occurred at 6:15 m., from the causes and on the date stated above.

SIGNATURE M. E. Easton (Degree or title) ADDRESS 3/17/57 DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Buried</u>	<u>March 19, 1957</u>	<u>Spring Hill</u>	<u>Easton</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>3/18/57</u>	<u>N. H. Reeves</u>	<u>Edison</u>	<u>Edison</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 6 1951
BUREAU T. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition
of 21 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02990

Form No. 6 151 MAR 27 1951 CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY Talbot		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland		COUNTY Caroline	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Easton		LENGTH OF STAY (in this place) 7 days		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Henderson			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print)		(First)		(Middle)		(Last)	
John				Gooden			
6. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married		8. DATE OF BIRTH Aug 20, 1873	9. AGE last birthday 77 yrs.	4. DATE OF DEATH (Month) (Day) (Year) March 7 1951	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Team driver		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. PLACE OF BIRTH (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME J.M. Hensan		14. MOTHER'S MAIDEN NAME Sarah Mingo		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT AND ADDRESS Mrs Rachael Jordan							

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Arteriosclerosis heart disease

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Fract. right left. hip.

(c)

INTERVAL BETWEEN ONSET AND DEATH

28 Feb 51

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE accident		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY home		(CITY OR TOWN)		(COUNTY)		(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY Feb 24, 1951 m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR? fall (3/29/51 acc)					

22. I hereby certify that I attended the deceased from 28 Feb, 1951, to 7 Mar, 1951, that I last saw the deceased

alive on 7 Mar, 1951, and that death occurred at 0720 m., from the causes and on the date stated above.

SIGNATURE

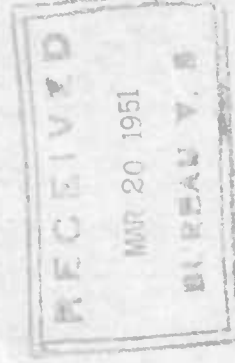
(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 3/10/51		NAME OF CEMETERY OR CREMATORY Greenwood		LOCATION (City, town, or county) Greensboro		(State) Md	
DATE REC'D BY LOCAL REG. 3/8/51		REGISTRAR'S SIGNATURE N.B. Neer		24. FUNERAL DIRECTOR R.B. Raulings		ADDRESS Greensboro			

380546 md



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02991

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton-Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton, Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Nettie</u>	(Middle) <u>Jane</u>	(Last) <u>Gross</u>
4. DATE OF DEATH	(Month) <u>March</u>	(Day) <u>19</u>	(Year) <u>1957</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Black</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>1-6-95</u>
9. AGE last birthday <u>56</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>Royal Oak, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter Gross</u>		14. MOTHER'S MAIDEN NAME <u>Charity Gibson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>213-227145</u>	
17. INFORMANT AND ADDRESS <u>Ruth E. Bryant, Easton RD. Md</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>carcinoma Of Uterus</u>		5 yrs
Antecedent cause(s) (b) <u>Undetermined</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>✓</u>		

II. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>		
19a. DATE OF OPERATION <u>Unknown</u>	19b. MAJOR FINDINGS OF OPERATION <u>Grade (3) Malignancy</u>	20. AUTOPSY? <u>XXXX</u> No <input type="checkbox"/> Yes <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE <u>No</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>XXXXXX</u>	(CITY OR TOWN) <u>XXXXXXXXXXXXXXXXXX</u> (COUNTY) <u>XXXXXX</u> (STATE) <u>XXXXXX</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>XXXXXX</u> m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> <u>XXX</u>	HOW DID INJURY OCCUR? <u>No injury</u>

22. I hereby certify that I attended the deceased from Feb 15, 1946, to Mar. 19, 1951, that I last saw the deceased alive on 3.18, 1951, and that death occurred at 11:35 A.M., from the causes and on the date stated above.

SIGNATURE Philip B. Lewis M.D. ADDRESS St. Michaels, Md DATE SIGNED 3.21.51

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Mar 22 1951</u>	NAME OF CEMETERY OR CREMATORY <u>St Paul Church</u>	LOCATION (City, town, or county) <u>Easton, Rural</u>	(State) <u>Md</u>
DATE REC'D BY LOCAL REG. <u>3/21/57</u>	REGISTRAR'S SIGNATURE <u>N.H. Neuw</u>	24. FUNERAL DIRECTOR <u>John D. Williams</u>	ADDRESS <u>Easton Md</u>	

720 836

Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 10 1951
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02992

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <u>Tallot</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>CAROLINE</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Easton</u>		LENGTH OF STAY (in this place) <u>74 hrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Preston</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hospital</u>				STREET ADDRESS (If rural, give location) <u>RD #1</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Hudson</u>	(Middle) <u>M.</u>	(Last) <u>HARRIS</u>	4. DATE OF DEATH (Month) <u>March</u> (Day) <u>27</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov 6, 1864</u>	9. AGE last birthday <u>86</u> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager - A. & P. Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Ind</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>Mr. J. Willet Harris</u>		14. MOTHER'S MAIDEN NAME <u>Harriet E. Patchett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT AND ADDRESS <u>Mr. Howard M. Harris, Preston, Ind</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral ThrombosisINTERVAL BETWEEN ONSET AND DEATH
3 wks

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Generalized Arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 3/27, 1951, to 3/27, 1951, that I last saw the deceasedalive on 3/27, 1951, and that death occurred at 6:20 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3/30/51</u>		NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		LOCATION (City, town, or county) (State) <u>Preston, Ind</u>	
DATE REC'D BY LOCAL REG. <u>3/27/51</u>		REGISTRAR'S SIGNATURE <u>N. A. Neer</u>		24. FUNERAL DIRECTOR <u>St. Mary's</u>		ADDRESS <u>Preston, Ind</u>	

290636

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02993

Reg. Dist. No. 294

1. PLACE OF DEATH COUNTY <u>Calvert</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u> TOWN <u>20 yr</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Calvert</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u> TOWN <u>Rural</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>MAMIE</u> (First) <u>MAE</u> (Middle) <u>HARRISON</u> (Last)		4. DATE OF DEATH <u>March 13</u> (Month) (Day) (Year) <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>MAY 6, 1889</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>66</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Bogman, Talbot Co. Md</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>B. C. Jones</u>		14. MOTHER'S MAIDEN NAME <u>Laurie B. Sherwood</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Miss Nellie Jones Calverton Ind</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Brain tumor</u>	<u>6 days</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Pneumonia</u>	<u>2 days</u>
	(c) <u>Pneumonia Recrud</u>	<u>10 yrs</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Post mortem</u>		<u>Pyc</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 13, 1957 to March 13, 1957, that I last saw the deceased alive on March 13, 1957, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

SIGNATURE <u>Lyman Reese, MD.</u> (Degree or title)		ADDRESS <u>Tilghman</u>		DATE SIGNED <u>March 14, 1957</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>	DATE THEREOF <u>3/16/57</u>	NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>	LOCATION (City, town, or county) <u>Easton, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>March 14, 1957</u>	REGISTRAR'S SIGNATURE <u>G. Wesley Swell</u>	24. FUNERAL DIRECTOR <u>Murphy & Harrison, St. Michael</u>		

MARGIN RESERVED FOR BINDING

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02994

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <u>Tacket</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Tacket</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Trappe</u>		LENGTH OF STAY (in this place) <u>6 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Trappe</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Ormond</u> (First) <u>Lee</u> (Middle) <u>Harrison</u> (Last)		4. DATE OF DEATH <u>March 23</u> (Month) <u>1951</u> (Year)			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec 1, 1880</u>	9. AGE last birthday <u>70</u> yrs.	If under 1 year: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u>		11. BIRTHPLACE (State or foreign country) <u>Tacket County, Md</u>	
13. FATHER'S NAME <u>Nicholas Harrison</u>		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INEORMANT <u>Oliver T. Harrison</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Coronary occlusion</u>		<u>7 days</u>
Antecedent cause(s) (b) <u>Arterio Sclerosis & Hypertension</u>		<u>7 years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 1, 1944, to Mar 23, 1951, that I last saw the deceased alive on Mar 23, 1951, and that death occurred at 6:15 A.M., from the causes and on the date stated above.

SIGNATURE William S. Beynolds (Degree or title) ADDRESS March 23, 1951 DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>March 23, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Trappe</u>	LOCATION (City, town, or county) <u>Trappe</u> (State) <u>Md</u>
DATE REC'D BY LOCAL REG. <u>3/24/57</u>	REGISTRAR'S SIGNATURE <u>N. H. Neeris</u>	24. FUNERAL DIRECTOR <u>Edwin East</u>	ADDRESS <u>Trappe</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

RECEIVED

RECEIVED
MAR 29 1961
FBI - NEW YORK

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02995

CERTIFICATE OF DEATH

Reg. Dist. No. 294

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>TALBOT</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>McDANIEL</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>McDANIEL</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>MARY</u>	(Middle) <u>W.</u>	(Last) <u>JONES</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>April 9, 1880</u>
9. AGE last birthday <u>71</u> yrs.		4. DATE OF DEATH (Month) <u>MARCH</u> (Day) <u>31</u> (Year) <u>1957</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>TALBOT County Md</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Webb</u>		14. MOTHER'S MAIDEN NAME <u>DEBORA HYNSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-05-3367</u>	
17. INFORMANT AND ADDRESS <u>MRS Dorothy Webb Black, McDANIEL</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>15 hrs</u> more	
Immediate cause (a) <u>Coronary Sclerotic Heart Disease</u>			
Antecedent cause(s) (b) <u>Arteriosclerosis</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arteriosclerotic Nephritis - Hypertension</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Fibroid Uterus</u>			
19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION <u>None</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE No for all	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>XXXXXX</u>	(CITY OR TOWN) <u>XXXXXX</u>	(COUNTY) <u>XXXXXX</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>XXXXXX</u> m.	INJURY OCCURRED <u>XXXXXX</u> Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>No injury</u>	
22. I hereby certify that I attended the deceased from <u>3.30.51</u> , 19....., to <u>3.31.51</u> , 19....., that I last saw the deceased alive on <u>3.31.51</u> , 19....., and that death occurred at <u>11:30 a.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Philip D. Lewis</u>		ADDRESS <u>M.D. St. Michaels, Md</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>April 4, 1957</u>	NAME OF CEMETERY OR CREMATORY <u>CLAIBORNE CEMETERY</u>	LOCATION (City, town, or county) (State) <u>CLAIBORNE, MARYLAND</u>
DATE REC'D BY LOCAL REG. <u>April 3-51</u>	REGISTRAR'S SIGNATURE <u>S. C. Lewis</u>	24. FUNERAL DIRECTOR <u>Newman & Harrison, St. Michaels, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

02996

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH- COUNTY <u>Talbot</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Calver.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>E. Aston</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Calvin Boy</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>16</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>March 14, 1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday yrs. <u>1</u> Mths. <u>2</u> Days <u>23</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Joseph Jordan</u>		14. MOTHER'S MAIDEN NAME <u>Abel Jordan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Abel Jordan</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a)

Prematurity

Antecedent cause(s)

(b)

Circumvallate Placenta

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

24 weeks gestation11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 3-14, 1951, to 3-16, 1951, that I last saw the deceasedalive on 3-16, 1951, and that death occurred at 1:30 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

J. Tyler Baker M.D. EastonMarch 20, 1951

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Cremation</u>	<u>3/16/51</u>	<u>Memorial Hospital</u>	<u>Easton</u>	<u>Md</u>
DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<u>3/16/51</u>	<u>N.H. Neeriv</u>	<u>Memorial Hospital Easton</u>		

20341193260

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 3 1951
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

02997

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH- COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Offord-Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Harrison Street</u>	
3. NAME OF DECEASED (First) <u>Theodora</u> (Middle) <u>Campbell</u> (Last) <u>Koehn</u>		4. DATE OF DEATH (Month) <u>Mar</u> (Day) <u>13</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 10-1882</u>
9. AGE last birthday <u>68</u> yrs.		10. If under 1 year Months <u>4</u> Days <u>3</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Montreal, Canada</u>		12. CITIZEN OF WHAT <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Campbell</u>		14. MOTHER'S MAIDEN NAME <u>Florence Burns</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Campbell Koehn, Offord, Md.</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary OcclusionINTERVAL BETWEEN ONSET AND DEATH
Instant

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 7/31, 1950, to 12/4, 1950, that I last saw the deceasedalive on 12/4, 1950, and that death occurred at 3:45 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u>	DATE THEREOF <u>Mar. 14-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	LOCATION (City, town, or county) <u>Bladensburg</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>3/13/51</u>	REGISTRAR'S SIGNATURE <u>N.A. Neuriss</u>	24. FUNERAL DIRECTOR <u>John D. Williams, Easton, Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 20 1961
FBI
U.S. DEPT. OF JUSTICE

Evidence for change
in 8 & 9 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02998

FILE No. G 131 APR 2 1951 CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH- COUNTY <u>Talbot Co.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>St Michaels</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Clayton</u> (First) <u>Lawrence</u> (Middle) <u>Lawrence</u> (Last)		4. DATE OF DEATH <u>March 18</u> 19 <u>51</u> (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 23, 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supplier (carber)</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>74</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Mr Lewis Lawrence</u>		14. MOTHER'S MAIDEN NAME <u>May Budger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
162x Immediate cause (a) <u>Bronchogenic Carcinoma</u>		<u>month +</u>
Antecedent cause(s) (b) <u>Hypertensive Cardiovascular disease</u>		<u>1 year +</u>
47c Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <u>Nov 49</u> , 19 <u>49</u> , to <u>March 17</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>March 17</u> , 19 <u>51</u> , and that death occurred at <u>5:57 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>C. D. Waite MD</u> (Degree or title)		ADDRESS <u>St. Michaels Md.</u> DATE SIGNED <u>3-21-51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/20/51</u>	NAME OF CEMETERY OR CREMATORY <u>St. Michaels</u>	LOCATION (City, town, or county) (State) <u>St. Michaels Md</u>
DATE REC'D BY LOCAL REG. <u>3/18/51</u>	REGISTRAR'S SIGNATURE <u>H. H. Neerup</u>	24. FUNERAL DIRECTOR <u>Norman H. Marshall</u>	ADDRESS

690609

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02999

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH - COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>2a</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesler, Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u>Donnerion</u>	
3. NAME OF DECEASED (First) <u>John</u> (Middle) <u>Thomas</u> (Last) <u>Lee</u>	4. DATE OF DEATH (Month) <u>3</u> (Day) <u>18</u> (Year) <u>1951</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (State) <u>Married</u>	8. DATE OF BIRTH <u>Sept 26, 1897</u>
9. AGE last birthday <u>53</u> yrs.		10. If under 1 year Months <u>3</u> Days <u>18</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Optician & Fishing</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Waterman</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mr. Frances B. Lee</u>		14. MOTHER'S MAIDEN NAME <u>Rachael A. Sherry</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Mr. Frank Lee, Chesler, Md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Carcinoma of Pancreas

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 3/5/51 19b. MAJOR FINDINGS OF OPERATION

Carcinoma of Pancreas

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☒ No ☐

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to 3/18/51, 1951, that I last saw the deceasedalive on 3/18/51, 1951, and that death occurred at 5:00 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

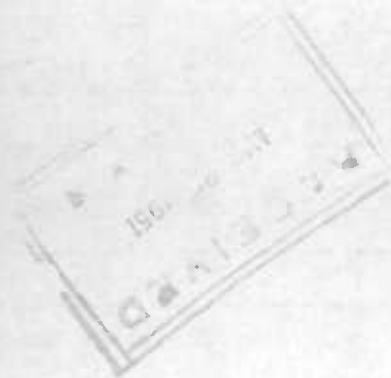
ADDRESS

3/18/51N.H. NeerEaston MdBox 200 - Centerville, Mdper R.G. Mowbray 9/10/26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 T



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03000

Reg. Dist. No. 290

1. PLACE OF DEATH- COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Outside of</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chardneck, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>none</u>	
3. NAME OF DECEASED (Type or Print) <u>Katie Ann</u> (First) <u>Sopau</u> (Middle) <u></u> (Last)		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>30</u> (Year) <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>none</u>	8. DATE OF BIRTH <u>Jan. 18/70</u> 9. AGE last birthday <u>87</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. FATHER'S NAME <u>James Golshoroukh</u>		12. CITIZEN OF WHAT COUNTRY? <u>and</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Brooks</u>	
15. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT AND ADDRESS <u>Gene Brooks</u>	

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Chronic Myocarditis</u>	<u>4-5 yrs</u>
Antecedent cause(s) (b) <u>Paraplegia</u>	<u>2 weeks</u>
(c) <u>none</u>	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>none</u>
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>
(CITY OR TOWN) <u></u> (COUNTY) <u></u> (STATE) <u></u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u></u> m.	INJURY OCCURRED While at <u>Work</u> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR? <u></u>	

22. I hereby certify that I attended the deceased from 4-5 yrs, 1957, to March 30/57, that I last saw the deceased alive on 3/30, 1957, and that death occurred at 9 A m., from the causes and on the date stated above.

SIGNATURE <u>Harward T. Trappe M.D.</u>	DATE SIGNED <u>4/3/57</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/3/57</u>
NAME OF CEMETERY OR CREMATORY <u>Trappe</u>	LOCATION (City, town, or county) <u>Trappe</u> (State) <u>Md</u>
DATE REC'D BY LOCAL REG. <u>4/3/57</u>	REGISTRAR'S SIGNATURE <u>N. H. Neer</u>
24. FUNERAL DIRECTOR <u>Louis B. Bayne</u>	ADDRESS <u>Cambridge</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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APR 6 1951
BUREAU, V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03001

CERTIFICATE OF DEATH

Reg. Dist. No. 290

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <u>Talbot</u> <u>County</u> <u>Easton</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Easton</u> TOWN <u>Easton</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Amos Easton Memorial Hosp.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Talbot</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> TOWN <u>Easton</u> STREET ADDRESS (If rural, give location) <u>112 North Wash St</u>	
3. NAME OF DECEASED (Type or Print) <u>Ms. Nadie</u>	(First) <u>Nadie</u>	(Middle) <u>North</u>	(Last) <u>North</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct 4, 1891</u> <u>79</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>St. W.</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>March 29</u> 1951 If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Talbot County Md</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Mr. William J. Covington</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Senelgir</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Mr. John C. North, Same as above</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

1712 Immediate cause (a) <u>Cerebral thrombosis</u>	INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>
480 Antecedent cause(s) (b) <u>Squamous cell carcinoma of cervix</u>	<u>Common</u>
(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u> HOMICIDE TIME (Month) (Day) (Year) (Hour) <u>m.</u> OR INJURY	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u> INJURY OCCURRED While at <input type="checkbox"/> Not While At work <input type="checkbox"/>	(CITY OR TOWN) (COUNTY) (STATE)
HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 2/1/51, 1951, to 29 Mar, 1951, that I last saw the deceased alive on 29 Mar, 1951, and that death occurred at 5:11 M. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>April 2, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	LOCATION (City, town, or county) <u>Easton</u>	(State) <u>Md</u>
DATE RECD BY LOCAL REG. <u>4/2/51</u>	REGISTRAR'S SIGNATURE <u>N. H. Harris</u>	24. FUNERAL DIRECTOR <u>W. H. Harris</u>	ADDRESS <u>Easton, Md</u>	



RECEIVED

APR 10 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 290

03002

1. PLACE OF DEATH- COUNTY <u>Talbot</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>		MARYLAND LENGTH OF STAY (in this place) <u>23 hrs.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md.</u> COUNTY <u>Talbot</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> TOWN STREET ADDRESS (If rural, give location) <u>406 August St.</u>	
3. NAME OF DECEASED (Type or Print) <u>John</u> (First) <u>William</u> (Middle) <u>Russ</u> (Last)		4. DATE OF DEATH <u>3</u> (Month) <u>29</u> (Day) <u>1957</u> (Year)			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>4/5/50</u>	9. AGE last birthday <u>11 mo.</u>	If under 1 year Months Days Hours Mln.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Ham. Hoof Easton Md</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13. FATHER'S NAME <u>Charles Russ</u>		14. MOTHER'S MARDEN NAME <u>Jane Austen</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	17. INFORMANT AND ADDRESS <u>Ms Charles Russ, 406 August St, Easton Md</u>		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Anuria - Uremia2 days?

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b) Acute + Chronic inflammatory disease colon.

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-28, 1951, to 3-29, 1951, that I last saw the deceasedalive on 3-29, 1951, and that death occurred at 9:50 A.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FLUENT DIRECTOR

ADDRESS

204050221404

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03003

CERTIFICATE OF DEATH

Reg. Dist. No. 290

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <u>Talbot</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Easton Md.</u> TOWN <u>Easton Md.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Caroline</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>East New-Market</u> TOWN <u>East New-Market</u> STREET ADDRESS (If rural, give location) <u></u>	
3. NAME OF DECEASED (Type or Print) <u>Jury</u> (First) (Middle) (Last)		4. DATE OF DEATH <u>March 13</u> 19 <u>51</u> (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Sept.</u>	8. DATE OF BIRTH <u>June 29, 1886</u> 6 <u>4</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE last birthday <u>64</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11a. FATHER'S NAME <u>Mr. William Said</u>		11b. MOTHER'S MAIDEN NAME <u>Mary France</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT AND ADDRESS <u>Mrs. Marie Dyer</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Pulmonary Emboli

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Acute Pulmonary Myocardial Infarction(c) Arteriosclerotic Heart Disease

INTERVAL BETWEEN ONSET AND DEATH

3/1/515/6/515 yrs

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) <u>SUICIDE</u> HOMICIDE <u></u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u></u> INJURY <u></u>	(CITY OR TOWN) <u></u>	(COUNTY) <u></u>	(STATE) <u></u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u></u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u></u>		

22. I hereby certify that I attended the deceased from 1/4, 1951, to 3/13, 1951, that I last saw the deceasedalive on 3/12, 1951, and that death occurred at 6:10 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/15/51</u>	NAME OF CEMETERY OR CREMATORY <u>Bruceville</u>	LOCATION (City, town, or county) <u>Bruceville Md</u>
DATE REC'D BY LOCAL REG. <u>3/14/51</u>	REGISTRAR'S SIGNATURE <u>N.H. Nevers</u>	24. FUNERAL DIRECTOR <u>Charles Stafford</u>	ADDRESS <u>Easton Md</u>

MARGIN RESERVED FOR BINDING

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03004

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH- COUNTY <u>Talbot</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hospital</u>		MARYLAND LENGTH OF STAY (in this place) <u>7 hrs.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Ridgely, Md.</u> COUNTY <u>Caroline</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>HARRY</u>		(First) <u>H.</u> (Middle) <u>S.</u> (Last) <u>Stayer.</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>10</u> (Year) <u>1957</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>June 12, 1897</u>	9. AGE last birthday <u>73</u> yrs.	10. If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer Machine Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>Penn</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Mr. David Stayer</u>		14. MOTHER'S MAIDEN NAME <u>Norman Stayer</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT AND ADDRESS <u>Mrs. Edna Stayer</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Heart's Coronary Thrombosis</u>	<u>12 hrs.</u>
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Generalized Arteriosclerosis</u>	
	(c) <u>Hypertension</u>	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-24, 1951, to 3-10, 1957 that I last saw the deceased alive on 2 AM 13-10-57, and that death occurred at 9:55 A.M., from the causes and on the date stated above.

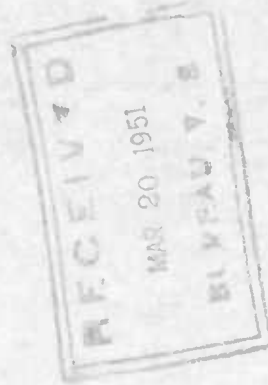
SIGNATURE <u>Chas. M. Stayer</u>	(Degree or title) <u>M.D.</u>	ADDRESS <u>Ridgely Md.</u>	DATE SIGNED <u>3-13-57</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/13/57</u>	NAME OF CEMETERY OR CREMATORY <u>Ridgely</u>	LOCATION (City, town, or county) (State) <u>Ridgely Md.</u>
DATE REC'D BY LOCAL REG. <u>3/11/57</u>	REGISTRAR'S SIGNATURE <u>N.H. Neer</u>	FUNERAL DIRECTOR <u>R.B. Rawlings</u>	ADDRESS <u>Greensboro Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

820105



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03005

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Wittman</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Helena</u>	(Middle)	(Last) <u>Warner</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Black</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>July 6, 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>61</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Miller</u>		14. MOTHER'S MAIDEN NAME <u>Katie Cooper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Catherine Johnson Wittman Rd</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral thrombosis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerotic heart disease & failure

(c)

INTERVAL BETWEEN ONSET AND DEATH 4 mos11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 5:00, 1951, to 2:00, 1951, that I last saw the deceasedalive on March 30, 1951, and that death occurred at 1:50 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>4/1/51</u>	<u>Wittman Md</u>	<u>Wittman</u>	<u>Md</u>
DATE RECEIVED BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>5/1/51</u>	<u>N. H. Neerie</u>	<u>Norman P. Marshall</u>	<u>St. Michaels, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 10 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03006

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u></u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>M. George</u>	(Middle) <u>W.</u>	(Last) <u>Williams</u>
4. DATE OF DEATH	(Month) <u>March</u>	(Day) <u>12</u>	(Year) <u>1951</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>May 25, 1871</u>
9. AGE last birthday <u>79</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>MD. Dorchester Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mr. Milburn Williams</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Wheatley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Ms. Randle Williams (son)</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Pulmonary embolism

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerotic heart disease - fibrine

(c) Diabetes mellitus

INTERVAL BETWEEN ONSET AND DEATH

31

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12 Feb, 1951, to 12 Mar, 1951, that I last saw the deceased

alive on March 12, 1951, and that death occurred at 7:55 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

3/13/51

N.A. Neerer

2111 Transp. Son

Federalburg Md.

100105

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 20 1951
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03007 290

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY <i>Talbot</i>				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Maryland</i> COUNTY <i>Talbot</i>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Rural Easton</i>				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Rural Easton</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (First)		(Middle)		(Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<i>William</i>		<i>Alonzo</i>		<i>Willis</i>		<i>March 25 1957</i>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year	If under 24 hrs.	
<i>Male</i>	<i>White</i>	<i>Married</i>	<i>Sept. 27, 1875</i>	<i>75 yrs.</i>	<i>5 Months</i>	<i>28 Days</i>	<i>1957</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<i>Farmer</i>			<i>Owner</i>		<i>Talbot County</i>		<i>U. S.</i>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>William Thomas Willis</i>				<i>Elizabeth Ellen Roberts</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY No.		17. INFORMANT			
<i>No</i>		<i>None</i>		<i>Mrs. Margaret May Willis (wife)</i>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <i>Arteriosclerosis, generalis</i>						<i>5 years</i>	
Antecedent cause(s) (b) <i>450.0 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</i>							
(c)							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1946</i> , to <i>3/25/57</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>3/24/57</i> , and that death occurred at <i>12:01</i> m., from the causes and on the date stated above.							
SIGNATURE <i>[Signature]</i>				ADDRESS <i>210 - Easton Md</i>		DATE SIGNED	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Buried</i>		<i>March 28, 57</i>		<i>Spring Hill</i>		<i>Easton Md</i>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<i>3/26/57</i>		<i>N.H. Morris</i>		<i>[Signature]</i>		<i>Easton Md</i>	

100105

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

DATE: APR 6 1951

TO: THE DIRECTOR OF THE BUREAU OF THE ARMY

FROM: THE DIRECTOR OF THE BUREAU OF THE ARMY

SUBJECT: THE DIRECTOR OF THE BUREAU OF THE ARMY

RE: THE DIRECTOR OF THE BUREAU OF THE ARMY

THE DIRECTOR OF THE BUREAU OF THE ARMY

THE DIRECTOR OF THE BUREAU OF THE ARMY

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RECEIVED
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

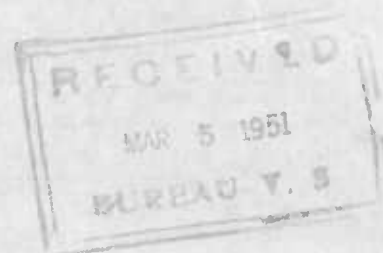
Reg. Dist. No. 291

03008

1. PLACE OF DEATH COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>McDaniel</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>McDaniel</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>MARY</u>	(Middle) <u>E.</u>	(Last) <u>WINK</u>
4. DATE OF DEATH	(Month) <u>March</u>	(Day) <u>3</u>	(Year) <u>1951</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>UNKNOWN</u>
9. AGE last birthday <u>OVER 100 yrs.</u>		10. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Noah E. Murdock</u>		14. MOTHER'S MAIDEN NAME <u>KATHERINE Plouman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Harry Codrington - McDaniel, Md.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Acute nephritis</u>		<u>3 days</u>	
Antecedent cause(s) (b) <u>590x</u> <u>130</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Feb. 26</u> , 19 <u>51</u> , to <u>Mar. 3</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Mar. 2</u> , 19 <u>51</u> , and that death occurred at <u>4 a.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>S. Penny Willson M.D. St. Michaels Md</u>		DATE SIGNED <u>3/3/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>3/6/51</u>	NAME OF CEMETERY OR CREMATORY <u>Hampstead</u>	LOCATION (City, town, or county) (State) <u>Hampstead - Carroll - Md.</u>
DATE REC'D BY LOCAL REG. <u>3/3/51</u>	REGISTRAR'S SIGNATURE <u>Mrs. Robert L. Bell</u>	24. FUNERAL DIRECTOR <u>NORMAN D. MARSHALL - St. Michaels, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 191

03009

1. PLACE OF DEATH COUNTY <u>Albort</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>St Michaels, Rural - 1 1/2 yrs</u> TOWN <u>St Michaels, Md. (Rural)</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Albort</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>St Michaels, Md. (Rural)</u> TOWN <u>St Michaels, Md. (Rural)</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Coughlin</u> (First) <u>Withers</u> (Middle) <u>Withers</u> (Last)		4. DATE OF DEATH <u>March 11</u> (Month) <u>1951</u> (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Retired</u>	8. DATE OF BIRTH <u>October 2, 1865</u>
9. AGE last birthday <u>85</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Architect</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>New York City N.Y.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	13. FATHER'S NAME <u>Fredrick B. Withers</u>	14. MOTHER'S MAIDEN NAME <u>Rebecca Alice High</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>
16. SOCIAL SECURITY No. <u>none</u>	17. INFORMANT AND ADDRESS <u>Clark Withers, St Michaels Md</u>		

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) <u>Coronary Occlusion</u>	<u>Instant</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Arteriosclerotic Heart Disease</u>	<u>Years</u>
(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov., 1949, to 3/10, 1951, that I last saw the deceased alive on 3/10, 1951, and that death occurred at 9:00 m., from the causes and on the date stated above.

SIGNATURE <u>Shepard Kuch Jr</u>	ADDRESS <u>M. D. Easton</u>	DATE SIGNED <u>3/12/51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Cremation</u>	DATE THEREOF <u>Mar 13/1951</u>	NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>
LOCATION (City, town, or county) (State) <u>Shadensburg, Md</u>	24. FUNERAL DIRECTOR <u>John D. Williams</u>	ADDRESS <u>Easton, Md</u>
DATE REC'D BY LOCAL REG <u>Mar 13/51</u>	REGISTRAR'S SIGNATURE <u>Wm. H. E. Seck</u>	

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RECEIVED
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BY DEPT. A